STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 123100-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _18th____ day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On August 30, 2011, attorney XXXXX, authorized representative of XXXXX(Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner, a resident of XXXXX, Michigan, receives health care benefits under a certificate of coverage issued by Blue Cross Blue Shield of Michigan (BCBSM). The certificate includes coverage for mental health and substance abuse treatment. That coverage is administered for BCBSM by Magellan Behavioral of Michigan, Inc.

Initially, the Petitioner's request for review was not accepted because the internal grievance process had not been completed. BCBSM later agreed that an August 19, 2011 letter from Magellan Behavioral should be considered a final adverse determination. The Commissioner accepted the request for an external review on September 14, 2011.

Because medical issues were involved, the case was assigned to an independent review organization which provided its analysis and recommendations to the Commissioner on September 28, 2011. (A copy of the complete report is provided to the parties with this order.)

II. FACTUAL BACKGROUND

The Petitioner has a lengthy history of substance abuse. On August 10, 2011, she sought treatment at XXXXX Memorial Hospital in XXXXX. On August 15, 2011, she was transferred to XXXXX Recovery Center, a substance abuse treatment facility affiliated with XXXXX. She was discharged from that facility on September 2, 2011. (She was treated at XXXXX Hospital from August 27 to August 29 for an adverse medication reaction.)

BCBSM denied coverage for the Petitioner's residential substance abuse treatment, ruling that she could have been treated at an outpatient level of care. The Petitioner appealed the denial through the BCBSM/Magellan internal grievance process. A final adverse determination was issued August 19, 2011, by Magellan, affirming the denial of coverage.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's residential substance abuse treatment?

IV. ANALYSIS

Petitioner's Argument

The Petitioner is 58 years old and has been struggling with drug and alcohol addiction since her twenties. In her twenties she was a heroine addict for nearly a decade. She eventually reached sobriety in 1988 after participating in Teen Challenge. For fifteen years she was able to manage her drug addiction, with only intermittent use of pain-killers.

In 2003, however, the Petitioner began extensive drug and alcohol use. She would have fits of extreme anger, threaten suicide and engaged in criminal activity, shoplifting, to support her addiction.

Throughout her struggles with addiction, the Petitioner has attempted numerous forms of treatment including Alcoholics Anonymous meetings, two residential stays, and seven months in Teen Challenge.

Prior to her admission to XXXXX the Petitioner confirmed with BCBSM that she had residential substance abuse benefits. BCBSM pre-authorized 5 days of detox and the first two days of her residential care at XXXXX. However, on August 16, 2011, Magellan contacted the medical director for the residential program at XXXXX and reversed BCBSM's approval. The Petitioner believes that her residential care at XXXXX was medically necessary and should be a covered benefit.

BCBSM's Argument

In its August 19, 2011 final adverse determination, Magellan stated that that the Petitioner's admission was not medically necessary based on its treatment criteria. The final adverse determination includes this explanation of the denial of coverage provided by Magellan's physician advisor:

> The member did not show evidence of requiring 24 hour/day, 7day/week supervision, intervention, and treatment in a therapeutic facility for detoxification or addiction recovery needs. Member did not have any reported medical or psychiatric conditions that would render unsafe treatment on an outpatient basis. There is no reported information that the member's home/social support environment would not support outpatient treatment.

Commissioner's Review

The question of whether it was necessary for the Petitioner to receive residential substance abuse care beginning August 15, 2011, was presented to an independent review organization (IRO) for analysis as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is a physician who has been in active practice for more than 18 years and who is board certified in psychiatry, addiction psychiatry, and addiction medicine. The IRO reviewer's report included the following analysis:

> At issue in this appeal is whether it was medically necessary for the member to have been treated at a residential level of care starting 8/15/11.
>
> [T]he member had no acute medical problems.… [T]he member had been detoxified from her opioid use prior to her admission to the residential level of care.… [T]he member claimed that she was "not ready to go home yet' and was admitted to residential care.… [T]he member had a long history of opioid use and did not necessarily have a sober living environment to which to return.…[T]he member needed a sober living environment, such as a half-way house or a sober house and an intensive outpatient level of care….[T]he American Society of Addiction Medicine patient placement criteria support treatment at an intensive outpatient level of care as of 8/15/11 for the member.…
>
> Pursuant to the information set forth above and available documentation…it was not medically necessary for the member to have been treated at a residential level of care starting 8/15/11.

While the Commissioner is not required in all instances to accept the IRO's recommendation, it is afforded deference. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation."

MCL 550.1911(16)(b). The IRO reviewer's analysis is based on expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in this case.

The Commissioner finds that BCBSM's denial of coverage was correct under the terms of the certificate.

V. ORDER

The final adverse determination of August 19, 2011, is upheld. The Respondent is not required to provide coverage for the residential substance abuse care that began August 15, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than 60 days from the date of this order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner